

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

### **I. DISPUTE**

1. a. Whether there should be additional reimbursement for dates of service 10/16/01 through 11/13/01.
- b. The request was received on 07/31/02.

### **II. EXHIBITS**

1. Requestor, Exhibit I:
  - a. TWCC 60 and position statement located on the Table of disputed Services
  - b. HCFAs-1500
  - c. TWCC-62 EOBs
  - d. Medical Records
  - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
  - a. TWCC 60 and Response to the Request for Medical Dispute Resolution
  - b. HCFA-1500
  - c. TWCC 62/EOB
  - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 01/15/03. The Respondent did not submit a response to the request. The "No Additional Information Received" sheet is reflected in Exhibit II of the Commission's case file. The carrier's initial responses, date stamped 08/26/02, 09/17/02, 09/18/02, and 11/11/02 are included in the case file reflected as Exhibit II and will be reviewed.
4. Notice of Supplemental Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

### **III. PARTIES' POSITIONS**

1. Requestor: Table of Disputed Services  
"We Billed \$136.00 per hr [sic] they pd \$36.00 per hr."

2. Respondent: Letter dated 08/26/02  
“...(Provider) used CPT code 97799 for the Pain Management Program....(MFG) 97799 is an unlisted physical medicine\rehabilitation service or procedure requiring DOP....(Provider) charged \$136.00 per hour for a total of 6.75 hours for each DOS...the (Carrier) requested additional documentation to substantiate the charge of \$ 136.00 [sic] per hour. (Provider) could not explain how they came up with the charge of \$ 136.00 [sic] per hour for all 6.75 hours,....Documentation included was vague as to how many hours were spent performing the regiment of this program.”

#### **IV. FINDINGS**

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 10/16/01 through 11/13/01.
2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer. Per the provider’s TWCC-60, the amount billed is \$12,852.00; the amount paid is \$3,402.00; the amount in dispute is \$9,450.00.
3. The carrier denied the billed services by code, “F – FEE GUIDELINE.”
4. The provider billed \$136.00 per hour for CPT code 97799-CP-AP, a DOP procedure (No MAR), per the MFG for the dates in dispute.

#### **V. RATIONALE**

Medical Review Division's rationale:

The Medical Fee Guideline Medicine Ground Rule (II) (G) (9) states, “Chronic Pain Management shall be billed as code 97799-CP...” Rule 134.304 (c) states, “At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission’s instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier’s action(s)...” The carrier failed to submit explanation of benefits which would provide the requestor with sufficient explanation to allow the provider to understand the reason for the denial.

The carrier raised the issue of documentation in it’s response to the request for medical dispute, but in accordance with 133.307 (j) (2), “The response shall address only those denial reasons presented to the requestor prior to the date the initial request for medical dispute was filed with the division and the other party. Responses shall not address new or additional denial reasons or defenses after the filing of an initial request. Any new denial reasons or defenses raised shall not be considered in the review.”

Because CPT code 97799-CP-AP has no MAR value, the carrier failed to provide sufficient explanation of benefits to allow the provider to understand the reason for the denial, "F". The carrier failed to support the denial code. Therefore, the carrier failed to meet the standards set forth in Rule 134.304 (c). Additional reimbursement in the amount of **\$9,450.00** is recommended.

The above Findings and Decision are hereby issued this 3<sup>rd</sup> day of March 2003.

Donna M. Myers  
Medical Dispute Resolution Officer  
Medical Review Division  
DMM/dmm

### **V. ORDER**

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$9,450.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 3<sup>rd</sup> day of March 2003.

Carolyn Ollar  
Medical Dispute Resolution Officer  
Medical Review Division

CO/dmm